MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53) X

CERTIFICATE OF DEATH

C4873

Reg. Dist. No. 183

1. PLACE OF DEATH:

County: Harford

City or town: Jarrettsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Harford

City or town: Jarrettsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Walter Feeney Bailey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Laura Rebecca Cudlipp

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Sept 14 1869

8. AGE: Years 76 Months 5 Days 26 If less than one day ... hrs. ... min.

9. Birthplace: Aldina Harford Co Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Retired

MOTHER FATHER

12. Name: Wm Bailey

13. Birthplace: Harford Co Md

MOTHER

14. Maiden name: Precilla —

15. Birthplace: Not Known

16. Informant: Mrs Wm Johnson

Address: Jarrettsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 13-46 (month) (day) (year)

Cemetery or crematory: Centre

Location: Forest Hill Md.

18. Funeral director: Martin E Kurtz

Address: Jarrettsville, Md.

19. May 13 1946 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10, 1946, at 3.15 P.M.

I CERTIFY that death occurred on the date above stated: that I attended deceased from January 1946 to May 1946 and that I last saw him alive on April 1, 1946

Immediate cause of death: Carcinoma with metastasis — DURATION: 3 yrs.

Due to: —

Due to: —

Other conditions: Mild Hypertension — ?

(Include pregnancy within 3 months of death)

Major findings of operations: None recently. Skin cancer 2 years ago. Date of op. August 1944

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Charles A. Neff M.D. M. D. or other

Address: Jarrettsville, Md. Date signed: May 11, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

C4874

Reg. Dist. No. 181

1. PLACE OF DEATH:
County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
~~City or~~ town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: W. L. Baldwin

3. (b) Social Security Number: No

4. Sex: Male
5. Color or race: White
6. (a) ~~Single, married, widowed, or divorced~~: Widower

6.(b) Name of husband or wife: Gertrude
Dead
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 11, 1865

8. AGE: Years: 80 Months: 8 Days: 14 If less than one day ..... hrs. ..... min.

9. Birthplace: Harford Co., Md.
(Town, county, and state)

10. Usual occupation: Filling Station Operator

11. Industry or business

FATHER
12. Name: Geo Baldwin
13. Birthplace: Harford Co., Md.

MOTHER
14. Maiden name: Lucinda Walker
15. Birthplace: Harford Co. Md.

16. Informant: Mrs. Margaret Barnsworth
Address: Aberdeen, Harford Co. Md.

17. Burial (Burial, cremation, or removal. Where?) Date thereof: May 27 1946 (month) (day) (year)
Cemetery or crematory: Union Chapel Cem.
Location: Harford Co., Md.

18. Funeral director: H. G. Bailey
Address: Darlington Md.

19. May 27 1946 Nellie H. Riley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 1946, at 9.9 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 18 1946, to May 25 1946, and that I last saw him alive on May 25 1946

Immediate cause of death: Acute Myocarditis — DURATION

Due to: Coronary Thrombosis

Due to:

Other conditions: Cardiac Failure
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles J. Foley M.D. M. D. or other
Address: Havre de Grace Md. Date signed: 5/27/46

VS-A15 9.45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

04875

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Near Bel Air, Md St Mary's Dist
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 42 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Near Bel Air St Mary's Dist
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Alice J Bond

3. (b) Social Security Number

4. Sex: F
5. Color or race: Col
6.(a) Single, married, widowed, or divorced: Widow.
6.(b) Name of husband or wife: Alexander Bond.
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): May 5 - 1869 ?
8. AGE: Years 76? Months Days If less than one day hrs. min.
9. Birthplace: Harford Co., Md (Town, county, and state)
10. Usual occupation: House Keeper
11. Industry or business
FATHER 12. Name: Ratt Collins
13. Birthplace: Md.
MOTHER 14. Maiden name: Jane Archer
15. Birthplace: Md
16. Informant: Lincy Johnson
Address: Bel Air, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 30/46 (month) (day) (year)
Cemetery or crematory: Hendon Hill
Location: Near Water Valve
18. Funeral director: Dean & Foster
Address: Bel Air, Md
19. 5/30 19 46 Priscilla Forwood Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27 1946 at 4 15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27 1946 to May 27 1946 and that I last saw her alive on May 25th 1946
Immediate cause of death: Cerebral Oedema — DURATION 5 wks
Due to: Senility
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE A. F. Van Tribber M. D., or other
Address: Bel Air, Md Date signed May 29 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45 10M

Evidence for the change of birth-date of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94

04876

CERTIFICATE OF DEATH

FILM NO. 104 JUN 17 1946

Reg. Dist. No. 183

1. PLACE OF DEATH: County: Harford

City or town: Madonna (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Madonna, Rocks R.D. (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Franklin Brock

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife: Lulu R. Clark

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov 15/11/1861 6/11 6, 1861

8. AGE:

Years	Months	Days	If less than one day
84	6	11	hrs. min.

9. Birthplace: Pocahontas Co. West Va.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Joseph Brock
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Not Known
15. Birthplace: Not Known

16. Informant: Gilbert L. Brock

Address: Rocks Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 30 1946 (month) (day) (year)

Cemetery or crematory: Emanuel

Location: Jobelia W. Va.

18. Funeral director: Martin L. Kurtz

Address: Jarrettsville Md.

19. May 31 1946 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 May 1946, at 10 50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 May 1946 to 26 May 1946 and that I last saw him alive on 26 May 1946

Immediate cause of death: Cardiac Decompensation — DURATION: 2 days

Due to: Arteriosclerotic Heart Disease — Prob. 15 years

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert A. Barthel M.D. M. D. or other

Address: Forest Hill, Md. Date signed: 27 May 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

C 4877

Reg. Dist. No. 186

1. PLACE OF DEATH:

County: Harford Memorial Hosp.

City or town: Havre de Grace (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred: Harford Memorial Hosp.

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Pylesville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Laura Butler

3. (b) Social Security Number

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: W

6.(b) Name of husband or wife: Thomas Butler

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): April — 1865

8. AGE: Years: 81 Months: Days: If less than one day ... hrs. ... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER 12. Name: unknown

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: unknown

MOTHER 15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Havre de Grace

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/18/46 (month) (day) (year)

Cemetery or crematory: St. Paul

Location: Maryland

18. Funeral director: W. H. Wells

Address: Swan Grove, Pa.

19. May 15 1946 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 1946 at 5 25 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 14 1946 to May 15 1946 and that I last saw him alive on May 15 1946

Immediate cause of death: Congestive Heart failure — DURATION: 20 min.

Due to: Etiology of Ht. disease

Due to: unascertained

Other conditions: dehydration & malnutrition

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Dudley Phillips M.D. M. D. or other

Address: Harford Memorial Hosp. Date signed 5/15/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48a) X

04878

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:

County: Harford

City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Day

Hospital, institution, or street address where death occurred:
Harford Memorial Hosp.

How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

Street No.: S. Washington
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Annie Deppish

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: Chas. Deppish (dec.)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 25 - 1878

8. AGE:

Years	Months	Days	If less than one day
68		10	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: —

FATHER
12. Name: Wm. Homer
13. Birthplace: Maryland

MOTHER
14. Maiden name: Catherine Colomn
15. Birthplace: Maryland

16. Informant: Robbins Deppish
Address: Dundalk, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/8/46 (month) (day) (year)

Cemetery or crematory: Grove

Location: Aberdeen

18. Funeral director: Pennington & Son
Address: Havre de Grace

19. May 7 1946 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5 1946 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2 1946 to May 5 1946 and that I last saw he alive on May 5 1946.

Immediate cause of death	DURATION
Congestive Heart failure	4 Day
Due to: Arteriosclerosis + Hypertension	
Due to: C.V. disease	
Other conditions: Diabetes Mellitus	
Carcinoma of cervix	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Dudley Gill M.D.
M. D. or other

Address: Harford Memorial Hosp. Date signed: 5/7/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

(4879)

Reg. Dist. No. 182

1. PLACE OF DEATH:

County: Harford Co

City or town: Darlington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Darlington

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Robert L. Detamore

3.(b) Social Security Number

4. Sex: M.

5. Color or race: W.

6.(a) Single, married, widowed, or divorced: ✓

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 10 - 1946

8. AGE: Years | Months | Days | If less than one day: 37 hrs. ..... min.

9. Birthplace: Castleton Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Robert L. Detamore

13. Birthplace: Md

MOTHER 14. Maiden name: Rosalie P. Stevens

15. Birthplace: Easton Md.

18. Informant: Robert L. Detamore

Address: Darlington Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 12 - 1946 (month) (day) (year)

Cemetery or crematory: Fork M. E. Cem

Location: Fork Md.

18. Funeral director: Clarence E. Cuthers

Address: Fork Md.

19. May 13 19 46 M. E. Kirk

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May - 12 19 46, at 6 30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 19 46, to May 12 19 46 and that I last saw him alive on May 11 19 46

Immediate cause of death: Premature birth — DURATION: 37 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: W. E. Gallion M. D. or other

Address: Darlington — Date signed: 5/12/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M C P I T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04880

Reg. Dist. No. 183

1. PLACE OF DEATH:

County: Harford

City or town: Morrisville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEceased:

(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Morrisville Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John C. Duncan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Carrie E. Duncan

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Dec 18 1869

8. AGE: Years 76 Months 5 Days 1 If less than one day ... hrs. ... min.

9. Birthplace: Harford Co. Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER 12. Name: Andrew Duncan

13. Birthplace: Harford Co. Md.

MOTHER 14. Maiden name: Ann Rutter

15. Birthplace: Harford Co. Md.

18. Informant: Perry Duncan

Address: Bel Air Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 22 1946 (month) (day) (year)

Cemetery or crematory: Morrisville M.E. Cemetery

Location: Morrisville Md.

18. Funeral director: F. Howard Webb

Address: Fallston Pa.

19. May 22 1946 Thomas R. Brown

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19 1946, at 12 noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 1946, to May 19 1946 and that I last saw alive on May 18 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to: Arteriosclerosis	1
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Evans M. Lee M.D. M. D. or other

Address: Churchtown Pa. Date signed: May 21 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1317)

CERTIFICATE OF DEATH

04881

Reg. Dist. No. 182

1. PLACE OF DEATH:

County: Harford

City or town: Near Bel Air Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Harford

City or town: Bel Air Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Jacob G. Wareham

3. (b) Social Security Number

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: W

6.(b) Name of husband or wife: Evalena Hamer

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Sept 4-1861

8. AGE: Years: 84 Months: Days: If less than one day ... hrs. ... min.

9. Birthplace: Harford Co Md (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER 12. Name: Wm A Durham

13. Birthplace: Md

MOTHER 14. Maiden name: Rachel A Gladden

15. Birthplace: Md

16. Informant: Mrs Ethel D Taylor

Address: Bel Air Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 22/46 (month) (day) (year)

Cemetery or crematory: Mt Zion

Location: Fountain Green

18. Funeral director: Deem & Foster

Address: Bel Air Md

19. 5/21/ 19 46 Priscilla Lowood (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19 1946, at 10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944 19 to May 19 1946 and that I last saw h... alive on May 19 1946

Immediate cause of death: Cerebral Hemorrhage — DURATION: 10 hrs

Due to:

Due to:

Other conditions: Chronic Nephritis — 7 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: F. P. Gorrgass M. D. or other

Address: Darlington Md Date signed: 5/20/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M I T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94

04882

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford
~~City~~ or town: Cardiff
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
~~City~~ or town: Cardiff
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Elizabeth Feeney

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Charles Feeney
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 7, 1867

8. AGE: Years	Months	Days	If less than one day
78	11	27	____ hrs. ____ min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Patrick Gribbin
13. Birthplace: Ireland

MOTHER
14. Maiden name: Bridget McSherry
15. Birthplace: Ireland

16. Informant: Mrs. Mary A. Kavanaugh
Address: 2806 E. Balto. St. Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 7, 1946 (month) (day) (year)
Cemetery or ~~crematory~~: St. Mary's
Location: Pylesville, Md.

18. Funeral director: Hubert P. Harkins
Address: Delta, Pa.

19. May 4 46 (Date rec'd by registrar) M. A. Kirk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 1946 at 9 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1941, to May 4 1946 and that I last saw h... alive on May 3 1946

Immediate cause of death: Coronary Thrombosis — DURATION: May 4
Due to: Generalized Arteriosclerosis
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Josiah A. Hunt M.D. (M. D. or other)
Address: Cardiff Md Date signed: 5/5/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

04883

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:

County: Harford

City or town: Havre de Grace (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Aberdeen (If outside city or town limits, write RURAL and give nearest town)

Street No. 22 Fenway Dr. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Henry Fisher Jr

3.(b) Social Security Number

4. Sex: Male

5. Color or race: Negro

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of ~~husband~~ or wife: Jessie Page Fisher

6.(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years: about 41 | Months: – | Days: – | If less than one day: hrs. min.

9. Birthplace: Starkville, Miss. (Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business: –

FATHER 12. Name: John H. Fisher

FATHER 13. Birthplace: Starkville, Miss.

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: "

16. Informant: Jessie Page Fisher (wife)

Address: 22 Fenway St. Aberdeen, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6/2/46 (month) (day) (year)

Cemetery or crematory: Jackson

Location: Jackson, Miss.

18. Funeral director: Pennington & Son

Address: Havre de Grace

19. 5-31 1946 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 1946 at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 to 19

and that I last saw h alive on — 19

Immediate cause of death: Fracture skull

Due to:

Due to:

Other conditions: Compound fracture both bones both legs

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 5/29/46

Where did injury occur? Havre de Grace (City or town) Harford (County) Md. (State)

Injured at home, farm, industry, public place (where?) Hwy 5 Route 40

Means of injury: Hit by auto Injured at work? no

23. SIGNATURE: Gerald C. Palmer MD Deputy Medical Examiner Harford County M. D. or other

Address: Bel Air, Md. Date signed: 5/29/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53-e X

04884

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County: Harford

City or town: Rural Forest Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Rural Forest Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Chestnut Hill

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Charles N. Grafton

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Annie Grafton

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): August 18, 1882

8. AGE: Years: 63 Months: 8 Days: 21 If less than one day: ... hrs. ... min.

9. Birthplace: Harford Co, Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Dairy

FATHER

12. Name: James O. Grafton

13. Birthplace: Harford Co, Md

MOTHER

14. Maiden name: Matilda Smith

15. Birthplace: Forest Hill, Md.

16. Informant: Mrs. Annie Grafton

Address: Forest Hill Md.

17. Burial (Burial, cremation, or removal) Date thereof: May 11, 1946 (month) (day) (year)

Cemetery or crematory: Deer Creek Cem

Location: Harford Co, Md.

18. Funeral director: H. S. Bailey

Address: Darlington, Md.

19. 5/10 19 46 Priscilla Fourwood

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 19 46, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 19 46, to May 9 19 46

and that I last saw him alive on May 9 19 46

Immediate cause of death: Sarcoma — Duration: 8 years

Primary sarcoma of right leg 8 years ago. Cause of death was metastatic sarcoma of spine.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Sarcoma of leg. Date of op. 1938

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other

Address: Forest Hill, Maryland Date signed: 5-10-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

C4885

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1702

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH:

County: Harford

City or town: Abingdon

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Dead on Arrival

Hospital, institution, or street address where death occurred:

Station Hospital, Aberdeen Proving Ground, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Alabama County: (Unknown)

City or town: Cottonwood

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route # 1

(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3. (a) FULL NAME

Moselma Hall 6 393 671

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Sept. 19, 1914

8. AGE:

Years	Months	Days	If less than one day
31	7	20	... hrs. ... min.

9. Birthplace: Cottonwood (Town, county, and state)

10. Usual occupation: Soldier

11. Industry or business

FATHER

12. Name: None listed J. W. Hall

13. Birthplace: Cottonwood, Ala.

MOTHER

14. Maiden name: ~~Unknown~~ Bonnie E. Hall

15. Birthplace: ~~Unknown~~ Cottonwood, Ala.

16. Informant: Bonnie Huff Hall (Mother)

Address: Route # 1, Cottonwood, Alabama

17. Transportation (Burial, cremation, or removal. Which?) Date thereof: May 11 1946 (month) (day) (year)

Cemetery or crematory: Johnson & Wickman Funeral Home

Location: Dothan Alabama

18. Funeral director: Howard K. McConnell

Address: Abingdon Maryland

19. May 11 1946 (Date rec'd by registrar) Marie M. Mouledale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 1946 at 8:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death: 1. Subdural Hemotoma 2. Petechial hemorrhages in brain substance

Due to: 3. Extensive lacerations of liver

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide (auto) Accident Date of May 9, 1946

Where did injury occur? Abingdon Harford Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Route 40

Means of injury Automobile Injured at work? No

23. SIGNATURE: Gerald C. Palmer M.D.

DEPUTY MEDICAL EXAMINER HARFORD COUNTY

M. D. or other

Address ... Date signed

I CERTIFY THAT I HAVE RECEIVED THE REMAINS OF THE ABOVE IN GOOD CONDITION

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04886

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred: 556 Green St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Havre de Grace Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 556 Greene St.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME Fannie Weiss Hecht

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Emanuel Hecht
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): June 13 - 1875

8. AGE: Years	Months	Days	If less than one day
70	10	24	hrs. min.

9. Birthplace: Balto. Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —
FATHER 12. Name: Jacob Weiss
FATHER 13. Birthplace: Bohemia
MOTHER 14. Maiden name: Virginia S. Black
MOTHER 15. Birthplace: Balto. Md
16. Informant: Jacob Hecht
Address: 556 Greene St
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/9/46 (month) (day) (year)
Cemetery or crematory: Hebrew Friendship
Location: Baltor Conckling St.
18. Funeral director: J. Ahrens & Co
Address: 243 W Reisterstown Rd.
19. May 7 1946 (Date rec'd by registrar) G. L. Jones M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1946, at 3:10 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1937, to May 7 1946, and that I last saw her alive on May 7, 1946.

Immediate cause of death	DURATION
Chronic Myocarditis	
Aortic Regurgitation	
Due to: Cardiac Failure	
Due to: Pulmonary Oedema	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE Charles J. Foley M.D. M.D. or other
Address Havre de Grace Md. Date signed 5/7/46

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Wolbert

WITHIN CORPORATE LIMITS ☐

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

04887

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 656 Franklin
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Robert Henry Himes

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Lillie May Himes (dec.)
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Feb. 5-1869

8. AGE: Years 77 | Months 3 | Days | If less than one day ... hrs. ... min.

9. Birthplace: Pennsylvania (town, county, and state)
10. Usual occupation: Retired Rail Road Carpenter
11. Industry or business: —

FATHER
12. Name: Wm. Himes
13. Birthplace: Pa.

MOTHER
14. Maiden name: Henrietta Bruffington
15. Birthplace: Pa

16. Informant: Mrs. Joseph Collins
Address: Havre de Grace

17. Buried (Burial, cremation, or removal. Which?) Date thereof: 5/9/46 (month) (day) (year)
Cemetery or crematory: Angel Hill
Location: Havre de Grace

18. Funeral director: Pennington & Son
Address: Havre de Grace

19. May 7 1946 A. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 1946, at 2.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1946, to May 6 1946 and that I last saw him alive on May 6 1946

Immediate cause of death	DURATION
Cerebral thrombosis	1 day
Due to: arteriosclerosis	10 yrs
Due to: Essential Hypertension	20 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank Wolbert M.D.
M. D. or other
Address: Havre de Grace Md. Date signed: 5-9-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(108)

CERTIFICATE OF DEATH

Reg. Dist. No. 18 (2)

1. PLACE OF DEATH:
County: Harford
City or town: Darlington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEACESED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Darlington
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: Robert S. Lawson

3. (b) Social Security Number: 214-18-5265

4. Sex: Male

5. Color or race: Colored

6.(a) Single, married, ~~widowed, or divorced~~: Married

6.(b) Name of husband or wife: Della Lawson

6.(c) If alive, give age: Alive years

7. Birth date of deceased (mo., day, yr.): Dec. 1, 1884

8. AGE: Years: 61 Months: 5 Days: 29 If less than one day: hrs. min.

9. Birthplace (town, county, and state): Harford Co., Md

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Anna Lawson
15. Birthplace: Harford Co., Md.

16. Informant: Mrs. Della Lawson
Address: Darlington, Md.

17. Burial (Burial, cremation, or removal (Which?)) Date thereof June 1 1946 (month) (day) (year)
Cemetery or crematory: Hosanna Cem.
Location: Harford Co., Md.

18. Funeral director: H. S. Bailey
Address: Darlington, Md.

19. May 30 19 46 (Date rec'd by registrar) M. M. Kirk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 1946 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 23 1946 to May 29 1946 and that I last saw him alive on May 29 1946

Immediate cause of death	DURATION
Lobar Pneumonia	4 days
Due to	
Due to	
Other conditions: Chronic Nephritis	2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: E. P. Snodgrass M. D. or other
Address: Darlington Date signed 5/30/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

C4889

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH

County: Harford

City or town: Abingdon
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 years

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Abingdon
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Francis A. Lee

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Mary A Lee

6.(c) If alive, give age: 85 years

7. Birth date of deceased (mo., day, yr.): Mar. 10, 1854

8. AGE: Years: 92 Months: 2 Days: 9 If less than one day: hrs. min.

9. Birthplace: Penna
(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER
12. Name: William T. Lee
13. Birthplace: Penna

MOTHER
14. Maiden name: Margaret Kincaid
15. Birthplace: Maryland

16. Informant: Granville Lee
Address: Abingdon Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: May 22 1946 (month) (day) (year)

Cemetery or crematory: Mountain Christian

Location: Joppa Maryland

18. Funeral director: Howard R. McConnaughey

Address: Abingdon Maryland

19. May 22 1946 (Date rec'd by registrar) Marie M Mouldside Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19 1946, at 3.55 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-2 1938, to 5-19 1946 and that I last saw h. alive on 5-19 1946

Immediate cause of death: coronary occlusion — DURATION: 1 day

Due to: generalized arterial sclerosis — 8 years
heart disease.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Fred O Hodges M.D. M. D. or other

Address: Edgewood Md Date signed: 5-20-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

C4890

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53)

CERTIFICATE OF DEATH

Reg. Diat. No. 183

1. PLACE OF DEATH:

County: Harford

City or town: Pylesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Pylesville R.D. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Henry Mastellen Lowe

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Emma Druel Lowe

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec 6, 1863

8. AGE: Years 82 Months 8 Days 10 If less than one day hrs. min.

9. Birthplace: Harford Co Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER 12. Name: Rufus Lowe

13. Birthplace: Harford Co Md

MOTHER 14. Maiden name: Rachael Ann Brown

15. Birthplace: Harford Co Md

16. Informant: Ruth Lowe

Address: Bridgeton Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 15 1946 (month) (day) (year)

Cemetery or crematory: Friends Cemetery

Location: Fawn Grove Pa

18. Funeral director: H. Howard Nesbit

Address: Fawn Grove Pa

19. May 15 1946 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 1946, at 6 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 11 1946, to May 12 1946 and that I last saw him alive on May 12 1946

Immediate cause of death: Carcinomas (Metastatic) (Primary in skin) — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Louis A. Hunt M.D. M. D. or other

Address: Cardiff, Md. Date signed 5/12/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C4831

Reg. Dist. No. 182

1. PLACE OF DEATH:

County: Harford

City or town: Belair (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Harford

City or town: Belair (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles C. McCleary.

3.(b) Social Security Number

4. Sex: M

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed.

8.(b) Name of husband or wife: Alice J McCleary.

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar 9 1865

8. AGE: Years: 81 Months: 2 Days: If less than one day: hrs. min.

9. Birthplace: York Co, Pa. (Town, county, and state)

10. Usual occupation: Railroad Worker.

11. Industry or business

FATHER 12. Name: Henry McCleary.

FATHER 13. Birthplace: York Co. Pa

MOTHER 14. Maiden name: Mary J McGuire

MOTHER 15. Birthplace: York Co, Pa.

16. Informant: Anna F McCleary.

Address: Belair, Md.

17. Buried (Burial, cremation, or removal, Which?) Date thereof: May 12 1946 (month) (day) (year)

Cemetery or crematory: Slate Ridge Cem.

Location: Delta, Pa.

18. Funeral director: Huber P Harbeno

Address: Delta, Pa.

19. 5/10 1946 Priscilla Fouwood (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9, 1946 at 9 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1943 to May 9 1946 and that I last saw him alive on Jan 15 1946

Immediate cause of death: Arteriosclerotic C. V. Disease — DURATION: 2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Gerald C Palmer MD M. D. or other

Address: Bel Air, Md Date signed: 5/9/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Sworn to before me, a Notary Public for the State of Maryland County of Harford, on this the 9th day of May, 1946.

Mae J. Kirk
Notary Public

C4892

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:

County: Harford

City or town: Rural Aberdeen
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Rural Aberdeen
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Post Road
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Mrs. Annie E. Moore

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband ~~or wife~~: Charles D. Moore

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 15 - 1861

8. AGE:

Years	Months	Days	If less than one day
84	10		..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: William B. Curtis

FATHER 13. Birthplace: Virginia

MOTHER 14. Maiden name: Elizabeth Payne

MOTHER 15. Birthplace: Virginia

16. Informant: Mrs. Claude L. Nelson

Address: Post Road, Aberdeen Md.

17. Burial
(Burial, cremation, or removal. Which?) Date thereof: May 29 - 1946
(month) (day) (year)

Cemetery or crematory: Grove

Location: Aberdeen Md.

19. Funeral director: Henry Tanning & Sons

Address: Aberdeen Md.

19. May 29 19 46 Nellie F. Riley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27 19 46 at 10:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 19 45 to May 27 19 46 and that I last saw her alive on May 26 19 46

Immediate cause of death	DURATION
Circulatory Failure	
Due to: Carcinoma of Breast	Mos.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. H. Delaney M.D.
M. D. or other

Address: Aberdeen Md. Date signed: 5/28/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83-C

Registered No. 04893

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Co.
(c) Hospital or institution: Perryman Md
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Perryman
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** JOSEPHINE POTOCKI

3 (b) If veteran, name war —

3 (c) Social Security Account No. NONE

4. Sex FEMALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife JOHN POTOCKI

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1868

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace POLAND (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name JOHN KOWALEWSKI
13. Birthplace POLAND

MOTHER
14. Maiden Name UNK.
15. Birthplace POLAND

16 (a) Informant VERA DAMESYN
(b) Address PERRYMAN MD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 21/46 (month) (day) (year)
(c) Cemetery or crematory HOLY ROSARY
Location BALTIMORE

18 (a) Funeral director Fred W Ogrodenski
(b) Address 1930 Eastern Ave

19 (a) 5/20/46 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1946, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1945, to May 18 1946, and that I last saw her alive on May 18 1946.

Immediate cause of death Cerebral Thrombosis — Duration 6 mo.

Due to Arteriosclerosis — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. **Signature** H K Draper M. D.
Address Perryman Md Date signed 5/20/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (737-0)

04894

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:
County: Harford
City or town: Aldino
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yr
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Rural Aberdeen, R.D. 2
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME James Edwin Riddle

3. (b) Social Security Number —

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Irene Hershey Riddle
6.(c) If alive, give age: — years
7. Birth date of deceased (mo., day, yr.): Nov. 8, 1859
8. AGE: Years 86 Months 6 Days 23 If less than one day hrs. min.
9. Birthplace: Balto. Co. Md. (Town, county, and state)
10. Usual occupation: Paper Hanger
11. Industry or business: Retired
FATHER 12. Name: Elijah Riddle
13. Birthplace: Md.
MOTHER 14. Maiden name: Emily Cole
15. Birthplace: Md.
16. Informant: Mrs. Helen E. Taylor
Address: Aberdeen, Md. R.D. 2
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 3, 1946 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore, Md.
18. Funeral director: R. Madison Mitchell
Address: Havre de Grace, Md.
19. June 2 1946 Beulah B. Knight Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20D. DATE OF DEATH: May 31 1946 at 12 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 1946 to May 30 1946 and that I last saw ~~him~~ alive on May 31 1946

Immediate cause of death: Coronary embolism — DURATION 6 hrs
Due to: chr. myocarditis
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Ralph Hollingsworth M.D. M. D. or other
Address: Churchville, Md. Date signed June 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185

64695

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Newborn
Hospital, institution, or street address where death occurred: Harford Memorial Hosp
How long in hospital or institution? Newborn

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Ohio County: –
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME Baby ~~Boy~~ Robinson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Baby

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.) May 6, 1946

8. AGE: Years	Months	Days	If less than one day
~~Full Birth~~		1	4 hrs. min.

9. Birthplace: Havre de Grace (Town, county, and state)
10. Usual occupation: none
11. Industry or business: —
12. Name (FATHER): Norton L. Robinson
13. Birthplace (FATHER): Springwater, N.Y.
14. Maiden name (MOTHER): Edith Cox
15. Birthplace (MOTHER): Ohio
16. Informant: Norton L. Robinson
Address: Havre de Grace
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/7/46 (month) (day) (year)
Cemetery or crematory: Angel Hill
Location: Havre de Grace
18. Funeral director: Pennington & Son
Address: Havre de Grace
19. May 7 1946 A. L. Lewis M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7 1946 at 2 30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6 1946 to May 7 1946 and that I last saw him alive on May 7 1946

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Dudley Phillips M.D. M. D. or other
Address: Harford Memorial Hosp
Date signed: 5/7/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

04896 P

Reg. Dist. No.

1. PLACE OF DEATH:
County: Harford County
City or town: Home We Share (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Harford
City or town: Aberdeen (If outside city or town limits, write RURAL and give nearest town)
Street No.: Celina House (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ~~Jacobs~~ Schnabel (Jacobs)

3.(b) Social Security Number

4. Sex: M
5. Color or race: W
6.(a) Single, married, widowed, or divorced:
6.(b) Name of husband or wife: Mary Schnabel
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): ~~3/5/66~~ March 19, 1867
8. AGE: Years: ~~79~~ 79 Months: 2 Days: 7 If less than one day: hrs. min.
9. Birthplace: Germany Md (Town, county, and state)
10. Usual occupation: Baker
11. Industry or business: Retired
FATHER 12. Name: Julius Schnabel
FATHER 13. Birthplace: Germany
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace: Germany
16. Informant: Mrs Margaret Kellard
Address: 423 S. Arrow St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-30-46 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore Md
18. Funeral director: Frederick A. Cole
Address: 1200 W. Lombard St.
19. 5/28/46 Ace Heden (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 1946 at 9:30 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 15 1946 to May 26 1946 and that I last saw h. alive on 5/25/46 1946
Immediate cause of death: Cerebral Embolism — DURATION: 6 hr.
Due to: Myocardial disease & Auricular fibrillation
Due to: Hypertensive Arteriosclerotic CV disease
Other conditions: Gangrene of Rt. foot
(Include pregnancy within 3 months of death)
Major findings of operations: Cerebral sclerosis Venous in Rt. leg
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dudley Sheldon M.D. Md M. D. or other
Address: Harford Memorial Hosp. Date signed: 5/27/46

04897

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (98)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Convalescent Home.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Harford
City or town: Bel air – Rural (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Annie Schultz

3. (b) Social Security Number

4. Sex: F
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: None
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Dec. 4, 1870
8. AGE: Years 75 Months 5 Days 8 If less than one day ... hrs. ... min.
9. Birthplace: Balto. Co. Md (Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER 12. Name: James H. Schultz
13. Birthplace: Balto. Co. Md.
MOTHER 14. Maiden name: Faith Mc. Kinley
15. Birthplace: Balto. Md.
16. Informant: Mrs. Thos. Biddison
Address: 432 N. Robinson St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/15/46 (month) (day) (year)
Cemetery or crematory: Ebenezer Methodist
Location: Baltimore County
18. Funeral director: Lassahn Funeral Home
Address: 7401 Belair Road
19. 5/20 1946 Priscilla Forwood (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1946 at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1946, to May 12 1946 and that I last saw her alive on May 11th 1946

Immediate cause of death: Gangrene of foot — DURATION 5 mos
Due to: Bilateral Lymphadenoma of legs — ?
Due to:
Other conditions:
(Include pregnancy within 8 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Willard P. Hudson M. D. or other
Address: Forest Hill, Md Date signed 5/13/46

M

I

VS A15 9-45 50M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (38)

CERTIFICATE OF DEATH

04898

Reg. Dist. No. 185

1. PLACE OF DEATH:

County: Harford

City or town: Havre De Grace (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred: Harford Memorial Hosp

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Perryman (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Kate Sexton

3.(b) Social Security Number: 216-20-3131

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: M

6.(b) Name of husband or wife: Charles J. Sexton

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Feb. 13, 1901

8. AGE: Years: 45 Months: 3 Days: If less than one day: hrs. min.

9. Birthplace (Town, county, and state): Sparta N.C.

10. Usual occupation: House wife

11. Industry or business

FATHER 12. Name: Felix Rector

FATHER 13. Birthplace: N.C.

MOTHER 14. Maiden name: Phebica Andrews

MOTHER 15. Birthplace: Va

16. Informant: Mrs. Charles J. Sexton

Address: Perryman Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 7 1946 (month) (day) (year)

Cemetery or crematory: Sparta

Location: Sparta N.C.

18. Funeral director: Henry J. Goring & Sons

Address: Riverdale Md

19. May 6 1946 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 1946 at 9:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1946 to May 6 1946 and that I last saw him alive on May 6 1946

Immediate cause of death	DURATION
Heart failure	5 days
Due to: Hyper Thyroidism	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Dudley Shelin M.D. M. D. or other

Address: Harford Memorial Hosp Date signed: 5/6/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS ☐

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

04899

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 hrs.
Hospital, Institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? 12 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Port Deposit, Rural (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Rebekah Whiteside Squier

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife:
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): July 9, 1860

8. AGE: Years 85 Months 10 Days 10 If less than one day ____ hrs. ____ min.

9. Birthplace (Town, county, and state): Cecil Co., Md.
10. Usual occupation: Teacher, retired
11. Industry or business: Public Schools.
FATHER 12. Name: Rev. John Squier
13. Birthplace: Scotland
MOTHER 14. Maiden name: Isabelle Wilson
15. Birthplace: Cecil Co., Md
16. Informant: C. C. Squier
Address: Port Deposit, Md
17. Burial (Bnrial, cremation, or removal. Which?) Date thereof May 22, 1946 (month) (day) (year)
Cemetery or crematory: West Nottingham
Location: Colora, Md. Rural
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.
19. May 21 19 46 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19 19 46, at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____
and that I last saw h____ alive on ____ 19____

	OURATION
Immediate cause of death: Fracture skull	12 hrs
Due to:	
Due to:	
Other conditions: Fracture R femur	12 hrs

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 5/18/46
Where did injury occur? Port Deposit (City or town) Cecil (County) Md. (State)
Injured at home, farm, industry, public place (where?) Highway
Means of injury: Auto accident Injured at work? No

23. SIGNATURE: Lawrence C. Palmer M.D. Deputy Medical Examiner Harford County M. D. or other
Address: Bel Air, Md. Date signed 5/19/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

WITHIN CORPORATE LIMITS ☐

C4900

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:

County: Harford

City or town: Havre de Grace (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DEACESED: (For newborn infants give residence of mother)

State: Md County: Harford

City or town: Street (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Harvey Stokes

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1866

8. AGE: Years 79 | Months | Days | If less than one day hrs. min.

9. Birthplace Street, Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farming

FATHER 12. Name John Stokes

13. Birthplace Street, Md

MOTHER 14. Maiden name Rebecca Scarborough

15. Birthplace Street, Md

16. Informant Hospital Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 3, 1945 (month) (day) (year)

Cemetery or crematory Friendly Cemetery

Location Dublin, Md.

18. Funeral director H. C. Bailey

Address Darlington, Md.

19. May 2 1946 C. L. Lewis M.D. Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1 1946 at 12:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/25 1946 to 5/1 1946 and that I last saw him alive on 5/1 1946

Immediate cause of death: Uremia — DURATION: 6 days

Due to: Chronic diffuse Nephritis

Other conditions: Pneumonia (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dudley Phillips M.D. M. D. or other

Address Harford Memorial Hosp Date signed 5/1/46

Evidence for the addition place of death is shown on FILM No. I 04 MAY 27 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

CERTIFICATE OF DEATH

Reg. Dist. No. 04901 182

1. PLACE OF DEATH: Harf

County

City or town: darlington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Dorsey Road
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Francis Ray Thomas

3.(b) Social Security Number: 705-12-4852

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Betty C. Thomas
Nee Edenbo

6.(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): March 1, 1916

8. AGE: Years: 30 Months: 2 Days: 11 If less than one day: hrs. min.

9. Birthplace: Connellsville, Pa
(Town, county, and state)

10. Usual occupation: Relief Engineer

11. Industry or business: Calvert Distillery Relay, Md.

FATHER
12. Name: Orvil Thomas
13. Birthplace: Summerfield Pa

MOTHER
14. Maiden name: Laura Lancaster
15. Birthplace: Fayette Co. Pa

16. Informant: Mrs. Francis R. Thomas
Address: Baltimore 25, Md. R.F.D. #9-Box 387

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5/17/46 (month) (day) (year)

Cemetery or crematory: Glen Burnie, Md

Location

18. Funeral director: Homer W. Singleton
Address: Glen Burnie, Md.

19. May 12 1946 M. M. Kirk
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 1946 at 10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Accidental Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 5/12/46

Where did injury occur? Darlington (City or town) Harford (County) Md (State)

Injured at home, farm, industry, public place (where?) Susquehanna River

Means of injury: Fell out of boat Injured at work? no

23. SIGNATURE: Gerald C. Palmer M.D.
Deputy Medical Examiner Harford County
M. D. or other

Address: Belair, Md. Date signed 5/12/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-c)

CERTIFICATE OF DEATH

04902

Reg. Dist. No. 182

1. PLACE OF DEATH:

County: Harford Co Md.

City or town: Fallston

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Fallston

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Dr. Burton Watkins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Aug 7-1886

8. AGE:

Years	Months	Days	If less than one day
59	9	7	hrs. min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Veteran

11. Industry or business

FATHER

12. Name: Isiah Watkins

13. Birthplace: Md.

MOTHER

14. Maiden name: Eliza Burton

15. Birthplace: Md.

16. Informant: Mrs. Burton Watkins

Address: Fallston Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 27-46 (month) (day) (year)

Cemetery or crematory: Fork M. E. Cem

Location: Fork Md.

18. Funeral director: Clarence E. Arthur

Address: Fork Md.

19. 5/25 (Date rec'd by registrar) 19 46 Priscilla Sowwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 May 19 46, at 7 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 May 19 46, to 24 May 19 46 and that I last saw him alive on 22 May 19 46

Immediate cause of death: Cardiac Decompensation

Due to: Malnutrition

Due to: Intestinal Malabsorption

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Charles Riedel M.D. M. D. or other

Address: Bel Air, Md. Date signed: 25 May '46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M